accepted POC - BR
11/5/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445075	A. BUILDING _____ B. WING _____	09/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTHCARE AND REHABILITATION CENTER	431 LARKIN SPRING RD MADISON, TN 37115

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F 000	INITIAL COMMENTS A Federal Monitoring Survey was conducted at the facility 9/22-25/14. The facility was not in substantial compliance with Medicare/Medicaid regulations at 42.CFR 483, Subpart B-Requirements for Long Term Care Facilities. The following deficiencies resulted in the facility's non-compliance. The census was 48.	F 000	**Disclaimer:** Madison Rehabilitation and Nursing does not believe and does not admit that any deficiencies existed either before, during or after the survey. The Facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan	
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, the facility failed to ensure that the location of the survey results report was made available to all residents (Resident #2). Additionally, there was no sign posted regarding the availability or location of the most recent survey results. The findings include: During entrance on 9/22/14 at 1 p.m., it was noted that the most recent survey report was locaed on the wall in the main lobby of the facility.	F 167	of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, the facility failed to ensure that the location of the survey results report was made available to all residents (Resident #2). Additionally, there was no sign posted regarding the availability or location of the most recent survey results. The findings include: During entrance on 9/22/14 at 1 p.m., it was noted that the most recent survey report was located on the wall in the main lobby of the facility.	F 167	of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.	

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 167	Continued From page 1 The book was not identified as containing survey results. . On 9/24/14 at 3:30 p.m., an interview was conducted with a resident council representative (Resident #2). When asked if she knew the location of the survey results report, she replied no. An environmental tour was conducted on 9/25/14 at 2:30 p.m. on all nursing units. During this tour, there were no obvious notices to residents or visitors indicating the location of the survey report book. The above finding was brought to the attention of the Administrator on 9/25/14 at 3:10 p.m., who confirmed the lack of signs identifying the location of the survey results.	F 167	**F 167 Right to Survey Results-Readily available** The facility must make the results available for examination and must post in an accessible place. The Administrator posted signs on 9/25/14 listing where the most recent survey results are located **Residents affected:** Resident #2 was provided the most recent survey results and was informed of the location of the survey results by the administrator. **Residents potentially affected:** All residents have the potential to be affected by this cited practice. The quality of life director/designee will report to the resident council members the results of the federal survey and location of the survey book. **Systemic measures:** The Administrator/designee The Administrator or designee will conduct a walk through weekly x 8 weeks to ensure the survey sign and book is posted an in the designated area. Any concerns identified with the survey book will be addressed immediately and reported to the administrator. **Monitoring measures:** The administrator will address concerns identified with the survey book immediately and report them monthly in QA x 2 months and upon occurrence thereafter.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and Quality of Life-Dignity Policy review, the facility failed to respect residents' dignity by not knocking or waiting for a response to enter resident rooms for two (2) of 37 Stage 2 sampled residents (Resident #'s 27 and 66). The findings include:	F 241		10/27/14

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F 241	Continued From page 2 1) Resident #27 was admitted to the facility on 1/3/06 with a past medical history that included glaucoma and anxiety. Review of the facility's policy entitled Quality of Life-Dignity (no date), revealed under bullet point number 6, "Resident's private space and property shall be respected at all times. Staff will knock and request permission before entering residents' room." During an observation on 9/23/14 at 10:27 a.m. and at 10:29 a.m., Dietary Staff #1 walked into Resident #27's room without knocking. 2) Resident #66 was admitted to the facility on 3/7/13 with a past medical history that included Fracture at C1-C4. On 9/23/14 at 10:39 a.m. during the resident interview, an employee knocked on Resident #66's door, opened it and looked in the room and then closed the door. The employee did not wait for a response from the resident to enter the room, nor did employee identify herself upon entering. In an interview on 9/25/14 with the Assistant Director of Nursing at approximately 10:00 a.m., she was asked what was the expectation of staff before entering a resident's room. She replied, "Expect staff to knock on the door prior to entering and to introduce themselves."	F 241	**F241 Dignity and respect of Individuality.** The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. **Resident affected:** Resident #27, #66 were interviewed by social services to determine if further interventions needed to be addressed. None noted. Dietary staff were in-serviced on 9/25/14. **Residents potentially affected:** All residents have the potential to be affected by this cited deficiency. Staff will be educated by the SDC/designee on knocking on resident's doors. **Systemic Measures:** The director of Nursing/designee will educate staff on knocking on resident's doors before entering, waiting on a response, and announcing who they are. The Social Services Director/designee will interview two residents related to knocking weekly x 8 weeks. Any concerns identified related to knocking will be reported to the administrator immediately. The administrator will address concerns related to knocking immediately. **Monitoring changes:** The Social Services director will report concerns related to knocking to the administrator weekly x 8 wks. Any concerns with knocking on doors will be addressed immediately and discussed in monthly QA x 2 months and upon occurrence thereafter.	10/27/14
F 256 SS=E	483.15(h)(5) ADEQUATE & COMFORTABLE LIGHTING LEVELS The facility must provide adequate and	F 256		

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F 256	Continued From page 3 comfortable lighting levels in all areas. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to provide mechanisms to turn off the light and exhaust fans in the resident bathrooms for eight (8) of 37 Stage 2 sampled residents. (Room #'s 3, 8, 15,16, 29, 30, 31 and 32). The findings include: During initial tour on 9/22/14 and room observations on 9/23/14, an on/off switch could not be located for the following rooms: 3, 8, 15,16, 29, 30, 31 and 32. On 9/23/14 at approximately 10:36 a.m., Licensed Practical Nurse #2 was asked how to turn the bathroom lights off in room 29. After searching for a switch, she stated, "Let me go ask the maintenance guy." She confirmed no switch was available. On 9/23/14 at approximately 10:38 a.m., Housekeeper #1 was asked how to turn the bathroom lights out in Room 29, she stated, "There are none. The lights stay on all the time." On 9/25/14 at approximately 3:25 p.m. the Plant Operations Manager was asked how to turn the bathroom lights off. He replied, "They hooked in the exhaust fans. Can't turn them off." When asked if he could hear the exhaust fans, he replied, "Yes, some of them are pretty loud." On 9/25/14 at approximately 3:00 p.m. in an	F 256	**F 256 Adequate & Comfortable lighting levels** The facility must provide adequate and comfortable lighting levels in all areas. **Residents affected:** Resident room lights were assessed by the maintenance director for rooms: 3, 8, 15, 16, 29, 30, 31, 32. The maintenance director/designee will install a mechanism to turn on and off to ensure adequate lighting in each room. **Residents potentially affected:** All residents have the potential to be affected by this cited practice. The maintenance director visually inspected all bathrooms in the facility for lighting and switch. . **Systemic measures:** The maintenance director/designee will visually inspect all rooms for adequate lighting in the bathroom along with switches to turn them on by 10/27/14. The maintenance director/designee will inspect lighting in bathroom monthly x 3 months and report any concerns identified to the administrator. The maintenance director will log inspections related to the bathroom lighting in TELS system monthly x 3 months. **Monitoring measures:** **The administrator will report in monthly QA** concerns identified during bathroom inspections x3 months.	10/27/14

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F 256	Continued From page 4 Interview with the Administrator, she was asked where the switch was for the resident's bathroom light and exhaust fan, she replied, I never seen where you couldn't turn the lights off before."	F 256		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interview, the facility failed to provide oral care according to the care plan for two (2) of 37 Stage 2 sampled residents (Resident #'s 51 and 63). The findings include: 1) Resident #51 was admitted on 12/28/10 with diagnoses of Muscle Weakness, Psychosis, Pruritic Disorder, Major Depressive Disorder with Psychotic Behavior, and Eczema. Review of his most recent Minimum Data Set (MDS) dated 7/8/14 revealed the resident scored 15 on his Brief Interview for Mental Status (BIMS), which indicated he was cognitively intact, and required extensive assistance of one person with personal hygiene. Review of Resident #51's current care plan dated 9/3/14 revealed: "...Self-care deficit-...assist with oral care as needed. Report changes to the nurse. He has dentures but does	F 282	**F 282 Services by qualified persons/per care plan** The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. **Residents affected:** Resident's #51, #63 oral care was provided by Certified Nursing Assistant immediately that day. **Residents potentially affected:** All residents have the potential to be affected by this cited practice. DON/Designee will conduct education for certified nursing assistance related to oral care. **Systemic measures:** The DON/Designee will educate Certified Nursing Assistance on oral care. The DON/designee will audit 5 residents oral care weekly x 8 weeks. Residents with oral care conducted less than daily will be addressed immediately with staff and remedial training provided. The DON/designee will report to the administrators concerns identified in her audit of oral care. **Monitoring measures:** The administrator will report in monthly QA x 2 months concerns identified with oral care.	10/27/14

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F 282	Continued From page 5 not use them ..." During observations on 9/23/14 at 9:55 a.m., and again on 9/25/14 at 11:35 a.m., Resident #51 was observed to have no natural teeth, and no dentures in place. During an interview with the resident on 9/25/14 at 11:35 a.m., he confirmed he did not have dentures. When asked if staff provide oral care by rinsing his mouth out or using swabs to clean his mouth, he replied, "No- they don't do anything with my mouth." During an interview conducted 9/24/14 at 3:40 p.m., Certified Nursing Assistant (CNA) #1 confirmed she provided oral care to Resident #51. She stated, "I use swabs to clean his mouth when I come in on my shift, and after supper." When asked where she documented the care she provided, she pointed to the kiosk on the wall and said the Director of Nursing (DON) would have to print off a sheet showing where care was recorded. During an interview with CNA #2 conducted 9/25/14 at 11:30 a.m., she confirmed she assisted Resident #51 with oral care. She stated, "We give him mouth wash to swish his mouth out." When asked where care provided to the residents is documented, she stated, "When we do care we chart it in the Kiosk Computer on the wall. We document all care that we do." Review of the kiosk care tracker log provided by the DON on 9/25/14, revealed oral care had been provided for Resident #51 only five (5) of the last 20 days.	F 282		

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F 282	Continued From page 6 2) Resident #63 was admitted to the facility on 2/23/12 with diagnoses of Depressive Disorder, Muscle Weakness, Osteoarthritis, Senile Dementia with Delusional Depressive Features, and Constipation. Review of the most recent MDS dated 7/10/14 revealed the resident had a BIMS score of three (3), which indicated the resident had severe cognitive impairment, and required total assistance of one (1) person with personal hygiene. Review of Resident #63's current care plan dated 1/20/14 revealed, "...I need routine oral care...provide mouth care as per ADL (activities of daily living) personal hygiene." Review of the care kardex used by the CNAs revealed, " Resident has his own teeth. Cue to brush teeth. " Resident #63 was observed on 9/23/14 at 4:55 p.m., and again on 9/24/14 at 4:00 p.m., to have brown colored debris around his natural teeth. During an interview conducted with CNA #1 on 9/24/14 at 3:40 p.m., she confirmed Resident #63 has his natural teeth. She further revealed she had to set up the residents oral care supplies and provide cues for the resident to brush his teeth, and the resident performed his own oral care. During an interview with CNA #3 conducted on 9/25/14 at 1:25 p.m., she revealed she performs oral care for Resident #63 one (1) time on her shift; after lunch. She added she documented care she provided in the Kiosk. Review of the kiosk care tracker log provided by the DON on 9/25/14 revealed Resident #63 had only received oral care during 14 of the last 20 days.	F 282		

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F 282	Continued From page 7 During an interview conducted with the DON on 9/25/14 at 3:00 p.m., she revealed she expected oral care to be completed at least one (1) time a day.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, facility documentation review entitled "Wound Care Protocols", the facility failed to perform wound care in a manner to promote wound healing for one (1) of 37 Stage 2 sampled residents (Resident #58). The findings included: Review of facility documentation entitled, Wound Care Protocols revised 2010 revealed the following under procedures, "3. Wash hands...4. Prepare a clean field. 5. Open sterile dressings and supplies using clean technique. Place them on the clean field. 6. Put on clean gloves and removed soiled dressing and discard immediately in plastic bag. Remove gloves, place in plastic bag. 7. Wash hands. Put on a pair of clean gloves."	F 309	**F 309 Provide Care/Services for highest well being** Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial wellbeing, in accordance with the comprehensive assessment and plan of care. **Residents affected:** Resident #58 was assessed by signs and symptoms of infection. None noted. **Residents potentially affected:** All residents have the potential to be affected by this cited practice. The treatment/wound care nurse was educated on donning gloves and washing hands prior to performing wound care. **Systemic measures:** The DON/designee will educate licensed staff on washing hands and donning gloves. The DON/designee will observe 2 treatments weekly x 8 weeks for proper hand washing and donning gloves. Any concerns identified with washing hands/donning gloves will be addressed immediately and corrected. **Monitoring Change:** The DON/designee will report to the administrators concerns identified with washing hands/donning gloves weekly. The administrator will review and discuss in monthly QA x 2 months and upon occurrence thereafter.	10/27/14

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F 309	Continued From page 8 An observation of wound care for Resident #58 was performed by Licensed Practical Nurse (LPN) #3 on 9/25/14 at 10:15 a.m. LPN #3 performed several tasks, then at 10:32 a.m. she donned a pair of gloves after washing her hands. With the same gloves, she lifted the resident's leg/foot, placed a protective barrier under both feet and cut the soiled gauze off the resident's foot with scissors. She proceeded to perform the treatment to the resident's foot without changing gloves or washing her hands.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interview, the facility failed to provide daily oral care for two (2) of 37 sampled residents (Resident #'s 51 and 63). The findings include: Cross refer to F282 1) Resident #51 was admitted on 12/28/10 with diagnoses of Muscle Weakness, Psychosis,	F 312	**F312 ADL care provided for Dependent residents** **A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming and personal and oral hygiene.** **Residents affected:** Resident's #51, #63 oral care was provided by Certified nursing assistant immediately that day. **Residents potentially affected:** All residents have the potential to be affected by this cited practice. DON/Designee will conduct education for certified nursing assistance related to oral care. **Systemic measures:** The DON/Designee will educate Certified nursing assistance on oral care. The DON/designee will audit 5 residents oral care weekly x 8 weeks. Residents with oral care conducted less than daily will be addressed immediately with staff and remedial training provided. The DON/designee will report to the administrators concerns identified in her audit of oral care. **Monitoring measures:** The administrator will report in monthly QA x 2 months concerns identified with oral care.	10/27/14

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F 312	Continued From page 9 Pruritic Disorder, Major Depressive Disorder with Psychotic Behavior, and Eczema. Review of his most recent Minimum Data Set (MDS) dated 7/8/14, revealed the resident scored 15 on his Brief Interview for Mental Status (BIMS), which indicated he was cognitively intact, and required extensive assistance of one person with personal hygiene. Review of Resident #51's medical record revealed he had a self care deficit and needed assistance with oral care. During observations on 9/23/14 at 9:55 a.m., and again on 9/25/14 at 11:35 a.m., Resident #51 was observed to have no natural teeth, and no dentures in place. During an interview with the resident on 9/25/14 at 11:35 a.m., he confirmed he did not have dentures. When asked if staff provide oral care by rinsing his mouth out or using swabs to clean his mouth, he replied, "No- they don' t do anything with my mouth." Review of the kiosk care tracker log provided by the Director of Nursing (DON) on 9/25/14, documented oral care had been provided for Resident #51 on five (5) of the last 20 days. 2) Resident #63 was admitted to facility on 2/23/12 with diagnoses of Depressive Disorder, Muscle Weakness, Osteoarthritis, Senile Dementia with Delusional Depressive Features, and Constipation. Review of the most recent MDS dated 7/10/14 revealed the resident had a	F 312		

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F 312	Continued From page 10 BIMS score of 3, which indicated the resident had severe cognitive impairment, and required total assistance of one (1) person with personal hygiene. Review of Resident #63's current care plan revealed, "...I need routine oral care...provide mouth care as per ADL (activities of daily living) personal hygiene.." Review of Resident #63's medical record revealed he required cueing to brush his teeth. Resident #63 was observed on 9/23/14 at 4:55 p.m., and again on 9/24/14 at 4:00 p.m., to have brown colored debris around his natural teeth. Review of the kiosk log provided by the DON on 9/25/14 revealed Resident #63 had received oral care on 14 of the last 20 days. Review of the facility's policy entitled, "Oral Hygiene" with no effective or revised date, did not reveal how often oral care should be provided to the residents of the facility. During an interview conducted with the DON on 9/25/14 at 3:00 p.m., she revealed she expected oral care to be completed at least one (1) time a day.	F 312		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids;	F 328		

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F 328	Continued From page 11 Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based observation, staff interview and policy documentation review entitled "Oxygen Therapy-Concentrator", the facility failed to maintain resident Oxygen equipment in a manner to prevent contamination that can cause infections. The deficient practice affects one (1) of 37 Stage 2 sampled residents (Resident #51). The findings include: On 9/25/14 at approximately 2:30 p.m., the environmental tour was conducted with the Director of Maintenance. An oxygen concentrator was observed in room #23 next to Resident #51's bed. The filter on the oxygen concentrator was noted to be encrusted with a white dust like material. When the Director of Nurses (DON) was questioned about this observation, on 9/25/14 at 4:00 p.m. she said that the oxygen concentrator's are monitored on a weekly basis and cleaned as needed. On 9/25/14 at 4:30p.m., the Oxygen Therapy - Concentrator policy (effective 12-2010) was reviewed. The policy did not indicate specific guidance for cleaning and/or replacing Oxygen concentrator filters.	F 328	**F328 Treatment/Care for special needs** The facility must ensure that residents receive proper treatment and care for the following services: Injections **Resident affected or potentially affected:** The concentrator filter in Room #23 was cleaned. All residents that use a oxygen concentrator have the potential to be affected. The maintenance director/designee cleaned the oxygen concentrator filters in the facility. **Systemic changes:** The maintenance director/designee will clean the filters to the oxygen concentrators weekly. The maintenance director/designee will provide a list to the administrator of the oxygen concentrators in the facility weekly x 8 wks that filters were cleaned. The administrator will conduct a weekly audit after receiving the list on oxygen concentrators to visualize filter for cleanliness x 8 wks. Any concerns identified will be corrected immediately with the filters. **Monitoring measures:** The administrator will report concerns identified with the oxygen concentrator filters to the monthly QA x 2 months and upon occurrence thereafter.	10/27/14

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F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record reviews and staff interviews, the facility failed to administer medications to residents without incurring a medication error rate of 8% (2 errors out of 25 opportunities). Medications were observed being passed on four (4) halls by four (4) nurses to two (2) of nine (9) residents. (Resident #'s 54 and 95. The findings include: 1) On 9/24/14 at 1:54pm, during the medication pass observation for Resident #54, Registered Nurse #1, poured and administered Sensipar 30mg (milligrams). Review of the September 2014, Physician's Order sheet revealed, Sensipar 30mg tablet, 1 tablet orally daily at 2 p.m. with food (take with 120mg=150mg). RN #1 only administered the 150 mg tablet, omitted the 120 mg tablet and administered the medication without food. In an interview on 9/25/14 at 4:26 p.m.with the Assistant Director of Nursing, she stated that she was unable to determine why Sensipar 120mg was not given. She also stated that it would be considered a medication error.	F 332	**F332 Free of medication error rates of 5% or more** **The facility must ensure that it is free of medication error rates of five percent or greater.** **Resident affected:** The NP was notified for Resident #54 with no new orders. The heparin was given to resident #95 using the correct syringe. **Residents potentially affected:** All residents have the potential to be affected by this cited practice. The DON/designee will educate licensed staff on medication administration. **Systemic changes:** The DON/designee will educate staff on medication administration. The SDC/designee will complete Medication administration competencies on licensed staff. The pharmacist along with the DON/designee will review the licensed nurse results after the competency has been completed. Any concerns identified with medication administration will be addressed and corrected immediately. The SDC/designee will report findings to the DON and administrator weekly x 8 wks. **Monitoring measures:** The administrator will report findings related to medication administration to the QA committee x 2 months and upon occurrence thereafter.	10/27/14

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F 332	Continued From page 13 2) On 9/24/14 at 3:18 p.m. during the medication pass observation of Resident #95, RN #2 removed a 100 unit-graduated insulin syringe from the medication cart and cleansed the injection port of the Heparin vial with an alcohol pad. She injected air into the vial and withdrew the Heparin from the vial. She filled the entire syringe with Heparin. When asked how much was in the syringe, she stated, "That's 1ml (milliliter) in the syringe." She also stated, "These are the only syringes that we have available to give the sub-q injections." Review of the September 2014, Physician's Order sheet read, Heparin 50,000 units/10ml; inject 1ml sub-q (subcutaneous) three times daily. On the same day at 3:32 p.m., RN #2 returned to the cart with the Assistant Director of Nursing (ADON). The ADON examined the syringe with this writer. She agreed that the wrong syringe was used to withdraw the Heparin. When asked how much Heparin was in the insulin syringe, she replied that she did not know because the wrong syringe was used.	F 332		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that Resident #95 was free from a significant error of administering the wrong	F 333		

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F 333	Continued From page 14 dose of Heparin during medication pass observation for one (1) of 37 Stage 2 sampled residents. The findings include: 1) On 9/24/14 at 3:18 p.m. during medication pass observation of Resident # 95, Registered Nurse (RN) #2, removed a 100 unit-graduated insulin syringed from the medication cart and cleansed the injection port of the Heparin vial with an alcohol pad. She injected air into the vial and withdrew the Heparin from the vial. She filled the entire syringe with Heparin. When asked how much was in the syringe, she stated, "That's 1ml (milliliter) in the syringe." She also stated, "These are the only syringes that we have available to give the sub-q injections." Review of the September 2014 physician's order sheet revealed an order for, Heparin 50,000 units/10ml; inject 1ml sub-q (subcutaneous) three times daily. On the same day at 3:32 p.m. RN #2 returned to the cart with the Assistant Director of Nursing (ADON). The ADON examined the syringe with this writer. She agreed that the wrong syringe was used to withdraw the Heparin. When asked how much Heparin was in the insulin syringe, she replied that she did not know because the wrong syringe was used. In an interview on 9/25/14 at approximately 10:00 a.m with the ADON, when asked what was the expected practice for licensed nurses to give an injection to a resident, she replied, "Pick an appropriate site; appropriate needle size; clean site prior to administration."	F 333	**F333 Residents free of significant med errors** **The facility must ensure that residents are free of any significant medications errors** **Resident affected:** The heparin was given to resident #95 using the correct syringe. **Residents potentially affected:** All residents have the potential to be affected by this cited practice. The SDC/designee will educate licensed staff on medication administration. **Systemic changes:** The DON/designee will educate staff on medication administration. The SDC/designee will complete Medication administration competencies on licensed staff. The pharmacist along with the DON/designee will review the licensed nurse results after the competency has been completed. Any concerns identified with medication administration will be addressed and corrected immediately. The DON/designee will report findings to the DON and administrator weekly x 8 wks. **Monitoring measures:** The administrator will report findings related to medication administration to the QA committee x 2 months and upon occurrence thereafter.	10/27/14

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F 333	Continued From page 15 Heparin is an anticoagulant (blood thinner) that prevents the formation of blood clots and can cause bleeding episodes while being used and for several weeks after it has been stopped.	F 333		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 431	**F431 Drug Records Label/Store Drugs & Biologicals.** Drugs and biologicals used in the facility must be labeled I accordance with currently accepted professional principles, and include appropriate accessory and cautionary instructions, and the expiration date when applicable. **Residents affected or potentially affected:** All medications were disposed of immediately after observation. All residents have the potential to be affected by this cited practice. The DON/designee will educate licensed staff on disposing expired drugs once removed from cart or turning into DON for pharmacist destruction. **Systemic changes:** The DON/designee will educate all licensed staff to destroy or turn in expired drugs on cart. The pharmacist will provide to the DON monthly a report of medication rooms and carts that expired drugs were observed on prior to their departure monthly x 3 months **Monitoring measures:** The DON will report to the administrator concerns identified with pharmacist report or observation during med pass any expired drugs left in cart. The administrator will report in monthly QA expired drugs left on cart x 2 months or upon occurrence thereafter.	10/27/14

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F 431	Continued From page 16 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and Policy Review entitled "Medication Storage, Storage of Medication", the facility failed to ensure that expired medications were disposed of after the expiration date for two (2) of four (4) medication carts. The findings include: Review of facility documentation entitled, Medication Storage, Storage of Medication dated 9/2010 reads, Outdated, contaminated, discontinued or deteriorated medications and those in containers that are cracked, soiled or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal ... " On 9/24/14 at approximately 4:32 p.m., the following items were observed on the North Hall Medication Cart with an expiration date of 6/30/14: 1) Ipratropium Bromide 0.5mg (milligrams) and Albuterol Sulfate 3 mg Vials: 6 pouches with 5 sterile unit-dose vials; 1 opened pouch with 4 sterile unit-dose vials; 1 pouch with 2 sterile unit-dose vials 2) 1 Heparin Solution 5,000units/10ml (milliliters) multi-vial dose bottle with no date open. During the observation, Registered Nurse (RN)	F 431		

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F 431	Continued From page 17 #2 confirmed that the Ipratropium Bromide 0.5mg (milligrams) and Albuterol Sulfate 3 mg Vials were expired and that the Heparin Solution did not have a date open displayed. When asked how long opened bottles are to be kept on the cart, she replied, "it's kept for 30 days or til it's used. " The following items were observed on the South Hall Medication Cart after their expiration date: 3) Two blister packs of Tramadol HCL (hydrochloride) 50 mg tablets with an expiration date 5/21/14 and 6/11/14. During the observation, RN #1 confirmed that the Tramadol blister packs were expired. All expired medications were immediately disposed of after observation.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441		

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F 441	Continued From page 18 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and facility policies review entitled "Medication Administration Sucutaneous and Handwashing and Use of Gloves", the facility failed to provide care in a manner that prevented the potential spread of infection by washing hands at the appropriate times for one (1) of four (4) sampled residents during medication pass observaton. (Resident #95). The findings included: Review of facility documentation entitled Medication Administration Subcutaneous dated 9/2010 reads, "3. perform hand hygiene 7. put on gloves."	F 441	**F441 Infection control, prevent spread, linens** The facility must establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. **Resident affected:** Resident #95 was assessed by signs and symptoms of infection. None noted. **Residents potentially affected:** All residents have the potential to be affected by this cited practice. The nurse was educated on changing gloves and washing hands prior to medication administration. **Systemic measures:** The DON/designee will educate licensed staff on washing hands and donning gloves. The DON/designee will observe med pass weekly x 8 weeks for proper hand washing and donning gloves. Any concerns identified with washing hands/donning gloves will be addressed immediately and corrected. **Monitoring Change:** The DON/designee will report to the administrators concerns identified with washing hands/donning gloves weekly. The administrator will review and discuss in monthly QA x 2 months and upon occurrence thereafter.	10/27/14

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F 441	Continued From page 19 Review of facility documentation entitled Handwashing and Use of Gloves dated 12/2010 reads, "hand washing will be performed before and after resident care is rendered and after handling contaminated articles." During the medication pass observation on 9/24/14 the following was observed: 1) At 3:13 p.m. while withdrawing the Heparin solution from the multi-dose bottle, Registered Nurse (RN) #2 touched the inner plunger with her unsanitized hand. At 3:38 p.m. RN #2 entered Resident #95's room. She did not sanitize hands prior to entering or once inside the room. She administered the resident's injection without gloves. At 4:15 p.m. RN #2 washed her hands, donned gloves, touched the medication cart, reached into her pocket and removed tissue, then cleaned nose/face. She walked into the resident's room and cleansed the bed side table with packaged Super Sani-cloth (a germicidal disposable wipe). Without removing her gloves, she exited the room, opened the medication cart, removed a small alcohol packet and cleansed her stethoscope. She re-entered the room and placed the bagged items on the bedside table before removing her gloves and washing her hands. In an interview on 9/25/14 at approximately 10:00 a.m. with the Assistant Director of Nursing, when asked, "when do you expect staff to sanitize hands?" She replied, "Before contact with patient."	F 441		